Appendices

APPENDIX A

THE 11 HIV/AIDS MENTAL HEALTH SERVICES DEMONSTRATION PROGRAM SITES

Alexandria Mental Health HIV/AIDS Project
Alexandria Community Services Board
720 North Saint Asaph Street
Alexandria, VA 22314

Center for AIDS/HIV Mental Health Services
Emory University
Grady Health System Infectious Disease Program
341 Ponce de Leon Avenue
Atlanta, GA 30308

Chicago HIV Health and Psychological Support Project
Cook County HIV Primary Care Center and Chicago Department of Health
1900 West Polk
Chicago, IL 60612

Kinship Connection
Department of Psychiatry/Elizabeth General Medical Center
655 East Jersey Street
Elizabeth, NJ 07206

SPECTRUM Community Services and Research
(Services for HIV Prevention, Education, Care, Treatment, and Research for Underserved Minorities)
Drew University of Medicine and Science
1774 East 118th Street, Building K
Los Angeles, CA 90059

APPENDIX A *(Continued)*

The Special Needs Clinic
Presbyterian Hospital
622 West 168th Street
New York, NY 10032

Harambee
Charles R. Drew Health Center, Inc.
2915 Grant Street
Omaha, NE 68111

The Community Living Room
COMHAR, Inc., and Philadelphia Office of Mental Health
207 North Broad Street, 5th Floor
Philadelphia, PA 19107

Mini Mental Health Center
Virginia Commonwealth University/Medical College of Virginia
P.O. Box 980109
Richmond, VA 23298

Walden House Planetree Assessment and Treatment Services
Walden House, Inc.
520 Townsend Street
San Francisco, CA 94103

Puerto Rico HIV/AIDS Mental Health Services Demonstration Project
Puerto Rico Department of Health
P.O. Box 70139
San Juan, PR 00936

PROCESS RECORDING OUTLINE

Student's Name:_____ **Client's Name:** _____ **Interview Date:** ___/___/___ **Session #:** _____
Date Submitted: ___/___/___ **Date Discussed:** ___/___/___

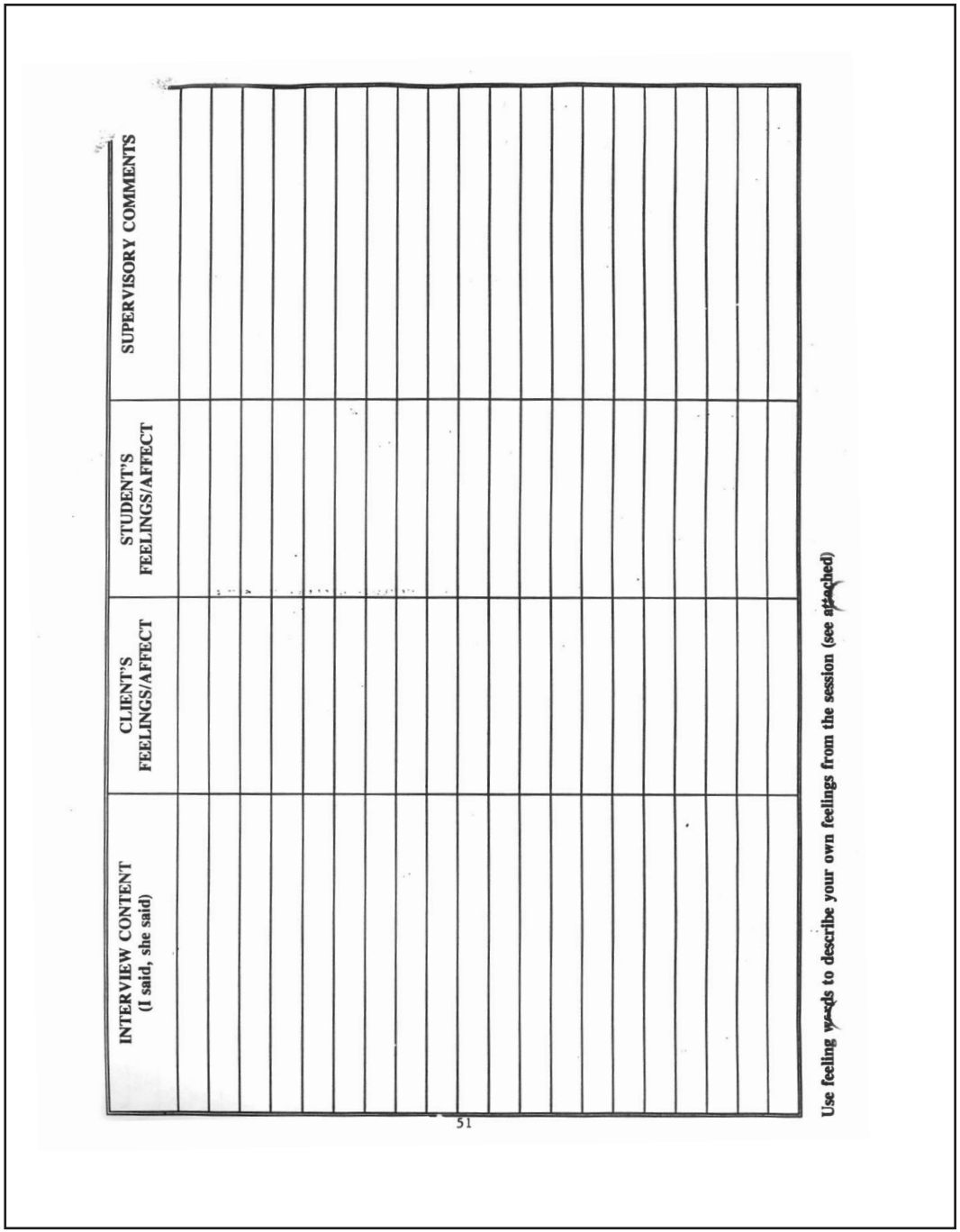
1. PURPOSE OF THE SESSION: (Statement of the purpose that is concise, clear and specific. Show relatedness between this session and the previous session).

2. CONTENT: (Using the recording form below, record one significant exchange in the beginning, in the middle, and at the end of the interview.)

INTERVIEW CONTENT (I said, she said)	CLIENT'S FEELINGS/AFFECT	STUDENT'S FEELINGS/AFFECT	SUPERVISORY COMMENTS

Use feeling words to describe your own feelings from the session (see attached).

APPENDIX B *(Continued)*



INTERVIEW CONTENT (I said, she said)	CLIENT'S FEELINGS/AFFECT	STUDENT'S FEELINGS/AFFECT	SUPERVISORY COMMENTS

Use feeling words to describe your own feelings from the session (see attached)

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APPENDIX B *(Continued)*

3. **IMPRESSIONS/ASSESSMENT: A) How did the client present her/himself - appearance, behavior and affect; B) What did you observe throughout the session -- behavior and affect; C) Was the behavior/affect appropriate, explain; and D) How does this behavior/affect fit with what you know about the client's past behavior affect?**

4. **IDENTIFY THE MAJOR THEMES/ISSUES THAT EMERGED:**

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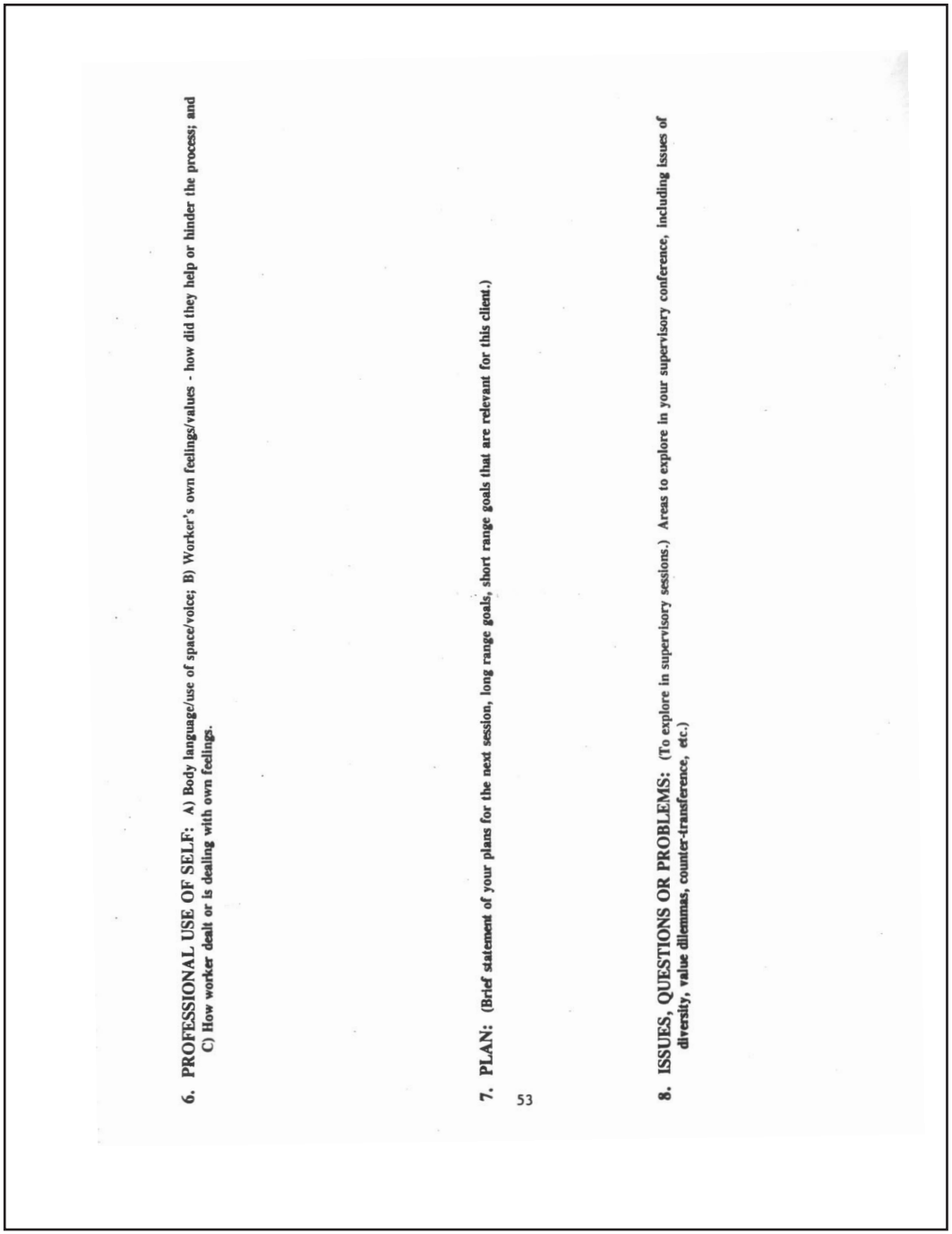
5. **INTERVENTIONS: Choose two significant interventions you made: A) Identify/describe; B) What was your impression of your effectiveness; and C) What would you change?**

APPENDIX B (Continued)



6. **PROFESSIONAL USE OF SELF:** A) Body language/use of space/voice; B) Worker's own feelings/values - how did they help or hinder the process; and C) How worker dealt or is dealing with own feelings.

7. **PLAN:** (Brief statement of your plans for the next session, long range goals, short range goals that are relevant for this client.)

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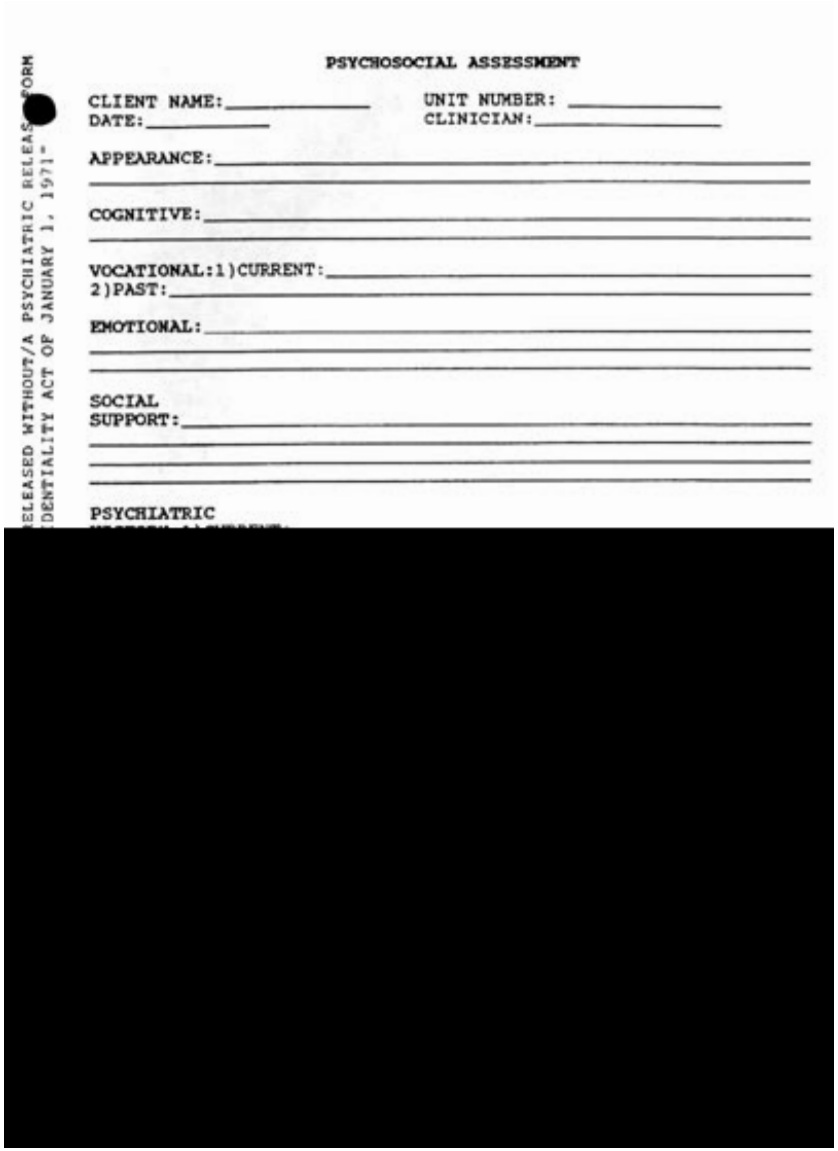
8. **ISSUES, QUESTIONS OR PROBLEMS:** (To explore in supervisory sessions.) Areas to explore in your supervisory conference, including issues of diversity, value dilemmas, counter-transference, etc.)

APPENDIX C



RELEASED WITHOUT/A PSYCHIATRIC RELEASE FORM
DENTIALITY ACT OF JANUARY 1, 1971"

PSYCHOSOCIAL ASSESSMENT

CLIENT NAME:_____ UNIT NUMBER: _____
DATE:_____ CLINICIAN:_____

APPEARANCE:_____

COGNITIVE:_____

VOCATIONAL:1)CURRENT:_____
2)PAST:_____

EMOTIONAL:_____

SOCIAL
SUPPORT:_____

PSYCHIATRIC

[redacted]

APPENDIX C (Continued)

GUIDE TO COMPLETING THE PSYCHOSOCIAL ASSESSMENT

In an attempt to provide greater uniformity in completing our psychosocial assessments. We thought providing some general guidelines on completing the various components would be helpful.

For each section we ask that you indicate in writing at minimum the following domains:

1) Appearance: Please comment on: a) age; b) ethnicity; c) gender d) build/height; e) dress; f) hygiene; g) Sexual orientation and risk factor if patient is forthcoming.

2) Mental Status: This section aims to provide a brief mental status of the patient at assessment. Please comment on the following areas: a) intelligence; b) judgment; c) memory (STM & LTM); d) thought disorder; e) delusions/hallucinations; and f) mood/emotional state.

   For example: pt is oriented x3, displays above average intelligence, memory appears intact, judgment intact, no indication of thought disorder or delusions/hallucinations and mood seems to be sad.

3) Suicide/homicide: If patient denies suicidal ideation at present, check denies and move on. If patient reports suicide or homicidal potential, elaborate with focus on ideation vs gestures vs attempts.

   For example: “pt reports having suicidal ideation w/o plan”; or “pt. has made suicidal gesture (took larger amount of meds than needed) but denies being suicidal at present”; or “pt. reports being suicidal has plan (slit wrists) and means

4) Psychiatric history: In this section, we would like to get an indication current and past psych. Tx. Indicate whether pt. is currently in tx by marking yes or no. If yes, indicate type frequency and duration (e.g. pt. is being seen at ISPI’s output. program on a weekly basis x 2yrs. or “Pt. Has recently been released from Read where he was hospitalized for 2 weeks for Suicide attempt”) If patient is aware of his diagnosis it may be helpful to indicate.

5) Substance Use: This section should provide a snapshot of pt. Drug use and indicate whether it is a factor in psychological functioning AT INTAKE. Specifically, indicate pt.’s primary drug of choice and attempt to get as accurate of an assessment of onset, frequency, and attempts to stop. The past use section should cover past substance abuse patterns and previous tx. For substance use. Below are a few examples of varying degrees of specificity:

   POOR: Pt. reports using various drugs on an intermittent basis. Past: pt reports have heroin prob. In past.

APPENDIX C (Continued)

BETTER: Pt. drinks alcohol and smokes marijuana occasionally. He does not identify substance use as a concern. Past: blank

BEST: Pt. indicates that he drinks (beer x3day/wk, 1 sixpack per day) Pt. uses cocaine (snorts lgm x 1/month). He reports onset of alcohol use at age 18 and cocaine use at age 27. No other drug use at present. Past: Pt. Has entered 3 detox programs (88, 94 & 95) never successfully completed drug tx. Program

6) Social support: This section has provided in the past a great deal of variability. It would be best to indicate social support along two domains (practical/financial and emotional). Practical support which would include assistance with daily living activities. Emotional support refers to who the person talks with to receive emotional support around living with HIV. Also, may want to assess level of HIV disclosure (to who and why and reasons not disclosed to others)

For example: "pt reports living w/ family who provide food, and transportation to medical appointments. Family not supported around emotional needs w/ family not telling other family member of pt's health status. Pt. Reports not talking to anyone about living with HIV"

6) Vocational: please indicate whether pt works full, pt, unemployed or unable to work at present. Indicate nature of work. (e.g. fast food or administration). For past, indicate primary job or job hx. (e.g. pt. Worked for gas company for 9yrs. or pt. held numerous part time jobs) You may want to comment on whether Pt. has concerns about HIV impacting work situation.

7) Initial Impressions: This section is the section where the most variability has existed. It may be best to conceptualize this section in the following way: 1) Consider the audience other health and social service staff; 2) "What would be helpful for them to know about the patient's psychological functioning?" and "what's your impression of this client's psychological management of his HIV diagnosis?" I would write very clearly (try to keep psychological jargon to a minimum) and provide concrete examples to substantiate your impressions. Providing an initial diagnosis is optional at present. Below is an example:

"Pt. is a 35 y/o gay AA male dx. HIV+ in 6/95. Pt. Appears to have cognitive impairments particularly in memory superimposed with active substance use, and failing health. Etiology for memory impairment is unclear but may be due to seizures, HIV, underlying psychosis (as evidenced by possible delusions) or a personality disorder. Preliminary diagnosis: Cocaine Abuse, R/O psychotic disorder, NOS. Pt. Does appear to respond well to structure and this should be factored in to tx. Planning.

8) Recommendations: self explanatory. Use "other" section for a more detailed discussion of tx. Rec.

APPENDIX D

The Mental Health SPECTRUM
Clinical Diagnostic Assessment

Date:

Clinician:

Patient Name:

Patient ID#:

ID(Gender, Race, Ethnicity, Age, D.O.B., HIV Status and Stage, Living Environment)

Source

Presenting Problem

Current Stressors

APPENDIX D (Continued)

Psychiatric Hx

Hospitalizations, where, reason

Family Hx

Medications

Previous Dx

ETOH/Drug Hx
Current Use (Substance, how much per day, how ingested)

Past Hx

Hospitalizations for SA

Treatment :current and past (counseling, groups, day treatment, 12 step)

Arrests, accidents, financial losses secondary to SA

Medical Hx
Past status

Current status

APPENDIX D *(Continued)*

Diagnosis

Medications

Surgeries

Social Development/Family Hx

Sexual Behavior & Orientation

Coping skills

Religious and/or Spiritual

Employment and Education

Legal

Financial

APPENDIX D *(Continued)*

Services Needed

- ☐ Transportation
  - ☐ voucher
  - ☐ dis bus pass
  - ☐ taxi ability card
- ☐ Disability
- ☐ Social Security
- ☐ Food Services

Psychosocial Needs

- ☐ 12 Step Program
- ☐ Case Management
- ☐ Child care
- ☐ Group(s)
- ☐ Housing
- ☐ Psychiatric Evaluation
- ☐ Medication Evaluation
- ☐ Neuropsych Consult
- ☐ Psychological Testing
- ☐ Individual Psychotherapy
- ☐ Couples Counseling
- ☐ Family Counseling
- ☐ Detox/Sober Living
- ☐ Domestic Violence

Mental Status Exam

Attitude, appearance and motor activity

Mood

- ☐ Depressed
- ☐ Euphoric
- ☐ Labile
- ☐ Dysphoric
- ☐ Angry/Hostile

Brief Description:

APPENDIX D *(Continued)*

Affect
□ Flat
□ Broad
□ Bright
□ Blunted
□ Inappropriate
Brief Description:

Structure of thought and speech

□rapid speech	□slurred speech	□within normal limits	□incoherent
□perseveration	□flight of ideas	□circumstantiability	□blocking
□neologisms	□tangentiality	□loose associations	□distractibility

□clang/associations/rhyming/punning
Brief Explanation:

Content of thought and speech

□preoccupation/rumination	□somatic concerns/hypochondriasis	
□derealization/depersonalization	□compulsions/obsessions	□grandiosity
□dreams and fantasies	□ideas of reference/influence	□excessive religiosity

□delusions: types and content_____
Brief Explanation:

Perception : hallucinations (types and content) and illusions

Sensorium and Cognition

Potential for destructiveness

APPENDIX D (Continued)

Suicidal attempts, thoughts and ideation

Insight and motivation

Summary

DSMIV DX
Axis 1

Axis 2

Axis 3

Axis 4

Axis 5

Problems

1.

2.

3.

Treatment Plan

1.

2.

3.

Signature Title Date

APPENDIX E

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE
ADMISSION/CRISIS INTERVENTION RECORD

CLIENT NUMBER:		**CLIENT NAME:**	
STAFF CODE:		**STAFF NAME:**	
PROGRAM CODE:		**PROGRAM NAME:**	
DATE OF REPORT:	**SVC:**	**MINUTES:**	**LOCATION:**

1. **Identifying Information:**

2. **Chief Complaint:**

3. **Presenting Problem with Precipitating Events:**

4. **Relevant History and Treatments** (include psychiatric, substance abuse, medical, criminal involvement, family relationships):
-- PSYCHIATRIC TREATMENT OR HISTORY:

-- SUBSTANCE ABUSE HISTORY:

-- MEDICAL:

-- CRIMINAL HISTORY:
-- FAMILY RELATIONSHIPS:

Service Location: AS = St. Asaph; PA = Patrick Street; JA = Jail; CL = Client Home; MI = Mill Road; CH = Charles Houston; CO = Community; HE = PIE; HO = Hospital/Training Center; CO = Colvin Street

APPENDIX E (Continued)

CLIENT NAME: CLIENT NUMBER:

5. **Mental Status Examination** (include current appearance, behavior, speech, affect, mood, content and process of thought, memory, orientation, abstraction, suicidal/homicidal ideation, potential for acting out, judgement and insight):
6. **Risk Assessment: Describe below and rate the level of risk.** (Consider especially a recent history, such as the last two weeks, of plans or attempts to commit suicide, violent or assaultive behaviors, threats of violence or fear-inducing behaviors such as throwing objects. Be particularly concerned with acute states of psychosis or substance abuse intoxication/withdrawal associated with potentially violent or self-destructive behaviors, and also note the degree of mental disorganization. Mention any remote history of suicide attempts of violent behaviors. Discuss involvement of recent losses, stressors, threatened or identified victims, availability of weapons/lethality of means, support system available, and demonstrated adaptive coping skills. Do not necessarily limit yourself to these factors.)

RISK LEVEL: Circle one.	
A. Elevated Risk: Current and/or recent history of suicidal plans or behaviors, violence, threats or similar acting-out behavior which may be associated WITH a disorganized mental state or substance abuse.	**B.** Concern of Risk: No recent history of the elevated risk factors, yet does have a history of suicide attempts, violence, or threats which may be associated WITH psychosis or substance abuse, and/or moderate risk factors in current presentation.
C. Low Risk: No past history of suicide attempts or violence, but clinical presentation contains some factors which raise concern.	**D.** No Concern of Risk. No risk factors present in client's history.

7. **Diagnostic Impression:**	**DIAGNOSIS**
	AXIS I:
	AXIS I:
	AXIS I:
	AXIS II:
	AXIS V (GAF):

APPENDIX E *(Continued)*

CLIENT NAME: CLIENT NUMBER:

8. **Initial Service Plan:** (Include immediate action required and taken, and follow-up plans; purpose; who, what, by when, and indication for hospitalization when appropriate.)

I have participated in the development of this service plan, have read the goals and objectives, and agree to its implementation.

CLIENT SIGNATURE: _____ DATE: _____

SIGNATURE OF QMHP, QMRP, OR QSAP _____ DATE: _____

APPENDIX E *(Continued)*

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE
CONSUMER ASSESSMENT

CONSUMER NUMBER:	**CONSUMER NAME:**
STAFF CODE:	**STAFF NAME:**
PROGRAM CODE:	**PROGRAM NAME:**
DATE OF ASSESSMENT:	**LOCATION:**

PURPOSE OF ASSESSMENT (check one): Initial ___ Follow-up ___ Crisis Intervention ___ Other (specify): _____

1. **Identifying Information:**
2. **Reason for Contact:**
3. **Presenting Problem with Precipitating Events:**
4. **Relevant History:**
   - Institutionalizations (Date/Place):
   - Hospitalizations (Date/Place):
   - Past Services (Date/Place):
   - Medications (Type/Amount):
   - Educational History:
   - Employment History:
   - Substance Abuse History:
   - Criminal Involvement/History:
   - Medical Problems:

Service Location: AS = St. Asaph; PA = Patrick Street; JA = Jail; CL = Consumer Home; MI = Mill Road; CH = Charles Houston; CO = Community; HE = PIE; HO = Hospital/Training Center; CO = Colvin Street

APPENDIX E (Continued)

CONSUMER NAME: CONSUMER NUMBER:

Family History/Support:
5. Mental Status (complete all sections):
Current appearance:
Behavior:
Speech:
Affect:
Mood:
Content process of thought:
Memory:
Orientation:
Abstraction:
Suicidal/homicidal ideation:
Potential for acting out:
Judgment:
Insight:
6. Risk Assessment (Describe below rate the level of risk).
Recent history (such as the last two weeks) of plans or attempts to commit suicide, violent or assaultive behaviors, threats of violence or fear-inducing behaviors such as throwing objects:
Acute state of psychosis or substance abuse intoxication/withdrawal associated with potentially violent or self-destructive behaviors, also note the degree of mental disorganization:
Any remote history of suicide attempts or violent behaviors (include dates):

APPENDIX E *(Continued)*

CONSUMER NAME: CONSUMER NUMBER:

Describe involvement of recent losses, stressors, threatened or identified victims, availability of weapons/lethality of means, support system available, demonstrated adaptive coping skills (do not necessarily limit yourself to these factors):

	FACTORS INCREASING RISK		(CHECK ALL THAT APPLY)		STRENGTHS REDUCING RISK
	Aggressive Behavior - Past		Denial of Mental Illness		Compliant with Treatment
	Aggressive Behavior - Recent		Access to Weapons		Compliant with Medications
	Fear Inducing Behaviors		Head Injury/Organic Brain Syndrome		Adaptive Coping Skills
	Aggressive Behavior Toward Property		Sexual Excitation Through Inappropriate/Aggressive Means		Has/Uses Strategies to Cope with Command Hallucinations
	Threats of Aggression		Intellectual Impairment		Social/Peer Support
	Aggressive Ideation		Suicide Attempts		No History of Violence
	Criminal History/Psychopathy		Suicidal Ideation		No Current Substance Abuse
	Anger or Repressed Hostility		Suicide Plans		Family (Significant Other) Support
	Homicidal Ideation		Suicide Attempts by Family Members		Acceptance of Mental Illness
	Impulsiveness by History		Non-Compliant with Medications		Insight into Mental Illness
	Paranoid Delusions		Non-Compliant with Treatment Plans		
	Sadistic Tendencies		Lack of Social Support		
	Command Hallucinations		Current Substance Abuse		

RISK LEVEL: Circle one.

A.	Elevated Risk: Current /or recent history of suicidal plans or behaviors, violence, threats or similar acting-out behavior which may be associated with a disorganized mental state or substance abuse.
B.	Concern of Risk: No recent history of the elevated risk factors, yet does have a history of suicide attempts, violence, or threats which may be associated with psychosis or substance abuse, /or moderate risk factors in current presentation.
C.	Low Risk: No past history of suicide attempts or violence, but clinical presentation contains some factors which raise concern.

APPENDIX E (Continued)

CONSUMER NAME: CONSUMER NUMBER:

7. **Diagnostic Summary of Assessment:**
DIAGNOSIS
AXIS I:
AXIS I:
AXIS II:
AXIS II:
AXIS III:
AXIS IV:
AXIS V (GAF):
8. **Initial Service Plan:** Immediate action required/taken: Follow-up plans (include purpose, by whom, by when, indication for hospitalization when appropriate):

I have participated in the development of this service plan, have read the goals objectives, agree to its implementation.

CONSUMER SIGNATURE: _____ DATE: _____

SIGNATURE OF QMHP, QMRP, OR QSAP: _____ DATE: _____

APPENDIX E (Continued)

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE
DIAGNOSTIC STUDY OF THE CLIENT

CLIENT NUMBER: **CLIENT NAME:**

STAFF CODE: **STAFF NAME:**

DATE OF REPORT:

1. REFERRAL INFORMATION (include source and reason):

2. HISTORY OF PRESENT CONDITION, ILLNESS, AND/OR SUBSTANCE ABUSE:

3. SOCIAL HISTORY:

A. Developmental Background:

B. Family Structure and Relationships:

C. Significant Milestones in Childhood or Adult Development:

D. Critical Incidents in Childhood or Adult Life (include trauma, victimization):

E. Employment/Vocational/Educational History (including current employment and military history, if any):

4. HISTORY OF AGGRESSIVE/CRIMINAL BEHAVIOR AND CURRENT CRIMINAL JUSTICE STATUS: NONE

5. SUBSTANCE ABUSE HISTORY: CLT REPORTS OCCASIONAL CANNABIS USE; TO EXPLORE FURTHER.

Substances Used	Age at Onset of Use	Frequency	Quantity	Method of Administration	Last Time Used
A. CURRENT:					
B. PAST:					

Is use sufficient to warrant further exploration? (Yes or No. If yes, complete C through M. If no, skip to 6).

C. Are/were substances used in either in combination or sequentially?

APPENDIX E (Continued)

CLIENT NAME: CLIENT NUMBER: Page 2

D. Client's reason for starting substance use:	
E. What purpose(s) does client believe that these substances have served?.	
F. Have any family members or significant others complained about client's alcohol or drug use?	
G. Has client ever done anything while intoxicated that s/he has regretted?	
H. Has substance abuse caused any trouble in the client's life (e.g., keeping family, child care or work responsibilities, financial or social obligations, or problems with physical or psychological well-being)?	
I. Does substance use recur in situations that are physically dangerous?	
J. Has the client ever committed any violent acts towards self or others while intoxicated?	
L. How long has the client attempted to maintain a drug-free lifestyle?	Presently attending AA/NA?
	AA or NA Sponsor?
M. do characteristic withdrawal symptoms occur if use of the substances is discontinued?	
6. **FAMILY HISTORY OF PSYCHIATRIC ILLNESS, SUBSTANCE ABUSE, SEXUAL/PHYSICAL ABUSE (by whom/against whom):**	
7. **FAMILY HISTORY OF SELF-DESTRUCTIVE, SUICIDAL OR HOMICIDAL BEHAVIOR (by whom, against whom, circumstances):**	
8. **RESULTS OF INDIVIDUAL PSYCHOLOGICAL, PSYCHIATRIC AND NEUROLOGICAL EXAMINATIONS, IF APPLICABLE:**	
9. **PREVIOUS MENTAL HEALTH AND/OR ALCOHOL/DRUG TREATMENT (include psychiatric hospitalizations):**	
10. **MEDICAL HISTORY:**	
A. Serious illnesses and chronic conditions of family members:	
B. Recent physical complaints/conditions; changes in or concerns about eating/sleeping patterns:	Date of last physical:
C. Past serious illnesses, infectious diseases, HIV testing, serious injuries, head trauma, hospitalizations:	
D. Physician/Dentist contact information: Physician Name, Address and Phone: Dentist Name, Address and Phone:	
11. **MEDICATION USE:**	
A. History of prescription and/or non-prescription drug use:	
B. Drug allergies, idiosyncratic and/or adverse drug reactions:	
C. Ineffective medication therapy:	

APPENDIX E *(Continued)*

CLIENT NAME: CLIENT NUMBER: Page 3

12. **MENTAL STATUS EXAMINATION:** (Include current appearance, behavior, speech, affect, mood, content and process of thought, memory, orientation, abstraction, suicidal/homicidal ideation, potential for acting out, judgment and insight.)

13. **RISK ASSESSMENT: Describe below and rate the level of risk.** (Consider especially a recent history, such as the last two weeks, of plans or attempts to commit suicide, violent or assaultive behaviors, threats of violence or fear-inducing behaviors such as throwing objects. Be particularly concerned with acute states of psychosis or substance abuse intoxication/withdrawal associated with potentially violent or self-destructive behaviors, and also note the degree of mental disorganization. Mention any remote history of suicide attempts of violent behaviors. Discuss involvement of recent losses, stressors, threatened or identified victims, availability of weapons/lethality of means, support system available, and demonstrated adaptive coping skills. Do not necessarily limit yourself to these factors.)

RISK LEVEL: Circle one.

A. Elevated Risk: Current and/or recent history of suicidal plans or behaviors, violence, threats or similar acting-out behavior which may be associated with a disorganized mental state or substance abuse.	**B.** Concern of Risk: No recent history of the elevated risk factors, yet does have a history of suicide attempts, violence, or threats which may be associated with psychosis or substance abuse, and/or moderate risk factors in current presentation.
C. Low Risk: No past history of suicide attempts or violence, but clinical presentation contains some factors which raise concern.	**D.** No Concern of Risk. No risk factors present in client's history.

14. **CLINICAL IMPRESSION:** (Include diagnosis, maintenance of current psychological and/or substance abuse problem, ego strengths and weaknesses, pathological personality traits, patterns of interpersonal relationships, impulsive and/or aggressive tendencies, responsiveness to previous interventions/medications, motivation for change.)
AXIS I

AXIS II
AXIS III
AXIS IV
AXIS V

APPENDIX E (Continued)

CLIENT NAME: CLIENT NUMBER: Page 4

PSYCHOSOCIAL ASSESSMENT	
15. Behavioral/Emotional Symptoms, Strengths, Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
16. Substance Abuse Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
17. Health Strengths, Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
18. Familial/Interpersonal Relationships Strengths, Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
19. Current Living Situation Strengths, Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
20. Vocational, Educational Strengths, Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
21. Social, Recreational Strengths, Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
22. Communication Strengths, Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
23. Transportation Strengths, Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
24. Financial Assistance Needs:	Service Need: Barriers to Service: Plan for Service Linkage:

APPENDIX E *(Continued)*

CLIENT NAME: CLIENT NUMBER: Page 5

25. Legal Assistance Needs:	Service Need: Barriers to Service: Plan for Service Linkage:
26. High Risk Behavior Management Needs (high-risk behaviors which currently pose an elevated risk to client or others, as described in #13).	Service Need: Barriers to Service: Plan for Service Linkage:

I have participated in the development of this service plan, have read the goals and objectives, and agree to its implementation.

CLIENT SIGNATURE: _____ DATE: _____

SIGNATURE OF QMHP, QMRP, OR QSAP _____ DATE: _____

APPENDIX E *(Continued)*

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE
MASTER INDIVIDUAL SERVICE PLAN

CONSUMER NUMBER: CONSUMER NAME:

UNIT/SUBUNIT: PROGRAM NAME:

CASE MANAGER STAFF CODE: CASE MANAGER NAME:

DATE FORM COMPLETED: Estimated length of consumer's need for service:

Objectives and strategies must include desired outcome, how (modality), who (responsible person) and frequency of planned service.

CONSUMER PROBLEM/NEED:	TARGET DATE	QUARTER			
		CODE/ DATE	CODE/ DATE	CODE/ DATE	CODE/ ANNUAL DATE
GOAL OF SERVICE:					
OBJECTIVES AND STRATEGIES:					
BARRIERS TO SERVICE:					

CONSUMER PROBLEM/NEED:	TARGET DATES	QUARTER			
		CODE/ DATE	CODE/ DATE	CODE/ DATE	CODE/ ANNUAL DATE
GOAL OF SERVICE:					
OBJECTIVES AND STRATEGIES:					
BARRIERS TO SERVICE:					

I have participated in the development of this treatment plan and agree with it.

Consumer Signature **Date**

CODES: C = Continue D = Discontinue OM = Objective Met MO = Modify Objective MS = Modify Strategy N = New Objective Added AR = Annual Review

APPENDIX F

Contract Agreement for Services
(Name of Evaluator)

THIS AGREEMENT, made and entered into by and between (Name of Evaluator), hereinafter referred to as "Evaluator," and (Name of Agency), a not-for-profit corporation duly organized and existing under the laws of the State of (Name of State), with a place of business at (Address of Agency), stipulates:

1. (Name of Agency) and Evaluator agree to enter into a relationship as described in this Contract, and to be bound by the terms of this Contract.

2. This Contract shall commence on (Start date), and shall continue until (End date).

3. Evaluator agrees to conduct a (Scope of work) with (target group). Such a (Scope of work) will include: (list of specific things that will be done).

4. (Name of agency) agrees to assist in these efforts by providing the following: (List of specific things the agency will provide).

5. Evaluator agrees to perform the services described in this Contract for (amount - hourly or payment for entire service). Evaluator will submit invoices and description of activities to (Name of Agency) on a _____ basis before receiving payments.

6. At their discretion, (Name of agency) shall compensate Evaluator for expenses incurred while conducting (scope of work), including: (list of expenses).

7. Evaluator acknowledges that all information received as a result of this agreement shall be deemed confidential, and Evaluator shall not release or reveal such information without the express, prior, written agreement of (Name of Agency). Evaluator understands that only aggregate data is sought, and to that effect, the confidentiality of individual participants in the individual and focus group interviews will be maintained. Evaluator agrees to take extensive notes during interviews, but will use audio or videotape equipment to record responses. If particular themes emerge, Evaluator may use non-identified quotes in the final report to further illustrate such themes. Because of the size of (Name of Agency) and the composition of the focus groups and individual interviews, it may be inferred from the final report whose perceptions are being presented.

APPENDIX F *(Continued)*

8. Evaluator acknowledges that in receiving, storing or otherwise dealing with any client information that they are bound by the requirements of 42 CFR part 2 and/or the Mental Health and Developmental Disabilities Confidentiality Act. Evaluator agrees to institute appropriate procedures for safeguarding information and to resist in judicial proceedings or other efforts to obtain access to any client information.

9. (Name of Agency) and Evaluator agree that any and all collected data will be the property of the (Identify who will own the data), and that the final report will be the property of (Name of Agency). Evaluator agrees that in any reference to the (Name of Agency) experience, the identity of (Name of Agency), its location, the identity of (Name of Agency) staff and community members, and the identity of any and all interviewees will remain confidential.

10. Evaluator acknowledges and understands that he/she is an independent contractor, and shall not be considered to be an employee of (Name of Agency) for any purpose.

11. (Name of Agency) acknowledges and understands that any services provided by the Evaluator beyond the scope of this CONTRACT will involve different fees for service and requires the development of a separate Contract agreement.

12. (Name of Agency) and Evaluator agree that this Contract agreement may be terminated by either party, with or without cause at any time, on sixty (60) days written notice.

In witness whereof, each party to this agreement has caused it to be executed at (Address of agency), on the date indicated below.

(Name of Agency): Evaluator:

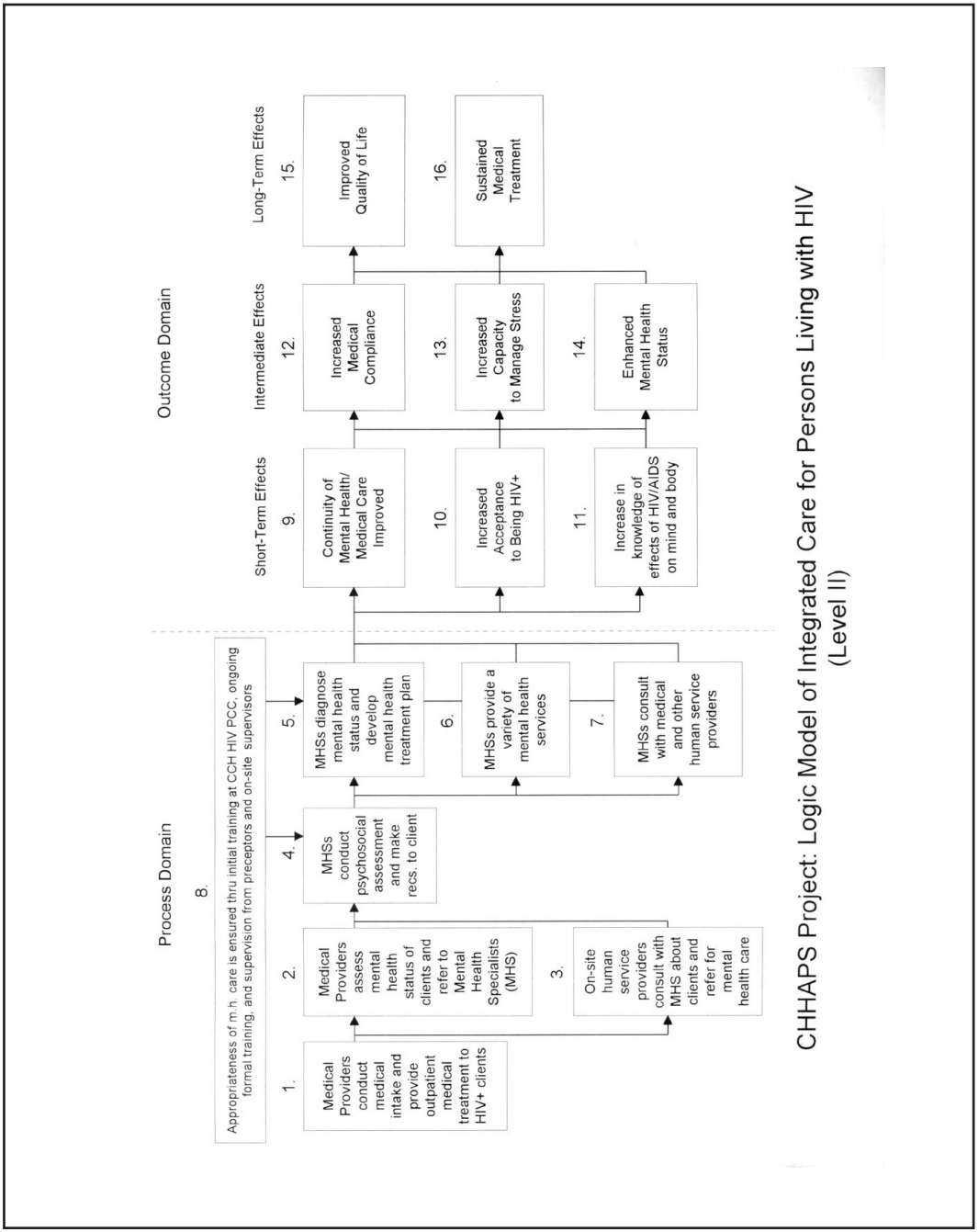
_____ _____

BY ITS EXECUTIVE DIRECTOR (Name of Evaluator)

_____ _____

DATE DATE

APPENDIX G


CHHAPS Project: Logic Model of Integrated Care for Persons Living with HIV
(Level II)
Process Domain
Outcome Domain
Short-Term Effects
Intermediate Effects
Long-Term Effects
8.
Appropriateness of m.h. care is ensured thru initial training at CCH HIV PCC, ongoing formal training, and supervision from preceptors and on-site supervisors
1. Medical Providers conduct medical intake and provide outpatient medical treatment to HIV+ clients
2. Medical Providers assess mental health status of clients and refer to Mental Health Specialists (MHS)
3. On-site human service providers consult with MHS about clients and refer for mental health care
4. MHSs conduct psychosocial assessment and make recs. to client
5. MHSs diagnose mental health status and develop mental health treatment plan
6. MHSs provide a variety of mental health services
7. MHSs consult with medical and other human service providers
9. Continuity of Mental Health/ Medical Care Improved
10. Increased Acceptance to Being HIV+
11. Increase in knowledge of effects of HIV/AIDS on mind and body
12. Increased Medical Compliance
13. Increased Capacity to Manage Stress
14. Enhanced Mental Health Status
15. Improved Quality of Life
16. Sustained Medical Treatment

APPENDIX H

12/2/96; serform.wpd

CHHAPS PROJECT
SERVICE ENCOUNTER RECORD

I. **Client's First Initial and Last Name:** _____

II. **Staff ID:**

III. **Date(s) of Service Encounter(s): see table below**

IV. **Category of Provider Agency:**

V. **Service Provided (*more than one may be recorded for each date of service*):**

III. Date of Service	A. Service Type(s)	B. Comp Status	C. Treatment Mode/Form	D. Duration	E. Location of Service
1.		08			
2.		08			
3.		08			
4.		08			
5.		08			
6.		08			
7.		08			
8.		08			
9.		08			
10.		08			
11.		08			
12.		08			
13.		08			
14.		08			

Office Use Only
Date Submitted to Data Coordinator or Administrative Assistant: _____
Date Entered into Computer: _____

APPENDIX H *(Continued)*

CHHAPS DCQC Manual; 12/1/96

SERVICE ENCOUNTER RECORD

PURPOSE OF THE FORM

The purpose of the multi-site Service Encounter Record (SER) is to uniformly collect information about the services provided and activities conducted by demonstration-funded staff across all eleven project sites.

DEVELOPMENT OF THE FORM

The SER was collaboratively developed by interested members of the Steering Committee, Coordinating Center, and Local Evaluators. It has gone through a minimum of three iterations. The final SER was developed on August 1, 1996, and approved by the Steering Committee in mid-August. It is available in hard copy and in English. In the future, it may also be available in a computerized version and in Spanish.

Although the general outline of the SER is used across all sites involved in the Demonstration Project, there are individual variations in the forms and data specifications (e.g., definitions of each of the service categories used in the SER) used at sites around the country. These variations are due to differences in the target populations and type of services delivered at each site. For example, the Local Evaluator and Data Coordinator of the CHHAPS Project developed the CHHAPS SER in order to better fit the needs of the CHHAPS Project. Without compromising the intent of the multi-site SER, the following steps were taken in the development of the CHHAPS SER:

- The Local Evaluator and Data Coordinator compared and contrasted drafts of the final SER with the crosswalk that was developed for the previous iteration of the SER and the current service tracking form - 1009 - utilized by the Mental Health Specialists at Englewood and Lakeview. The fields which CHAAPS staff utilize on the final SER were highlighted by the four Mental Health Specialists and communicated to the Data Coordinator.

APPENDIX H *(Continued)*

- The Local Evaluator and Data Coordinator developed the CHHAPS SER, which encompasses the fields highlighted by the Mental Health Specialists and the intent of the multi-site SER.

- In mid-August, the Data Coordinator showed the Mental Health Specialists the first iteration of the CHHAPS SER. During the group training of the CHHAPS SER, suggestions were made by the Project Director and Mental Health Specialists regarding additional modifications to the data specifications and form.

- The CHHAPS SER was finalized by the Local Evaluator and Data Coordinator in late August, 1996. A copy of the CHHAPS SER data specifications and form was submitted to RTI in late August, 1996, for review and comment.

TRAINING ON THE FORM

The Mental Health Specialists were trained in late August, 1996, on the intent and use of the CHHAPS SER. The following protocol was used:

- The Data Coordinator provided a group didactic presentation of the CHHAPS SER at the August local evaluation meeting to the Mental Health Specialists, Local Evaluator, and Project Director. This involved going through the entire CHHAPS customized data specifications document, item by item, discussing the application of each code, and comparing 1009 codes to SER codes.

- The Data Coordinator met individually with Mental Health Specialists to answer site specific questions related to the CHHAPS SER. He documented the questions and his answers.

- At the September and October local evaluation meetings, the Data Coordinator led a discussion on “common errors” and resolutions. There is a standardization in definitions and use of the CHHAPS SER across all four Mental Health Specialists.

ADMINISTRATION OF THE FORM

During the didactic training on the CHHAPS SER, it became evident that there was a lot of redundancy between the CHHAPS SER and the 1009s. It was also noted, however, that the 1009s tracked services in a more “broad brush stroke” way compared to the CHHAPS SER. In order to avoid having the Lakeview Mental Health Specialist

APPENDIX H *(Continued)*

spend too much time doing paperwork AND in order to assure that the original intent of the multi-site SER is not compromised, the following procedures have been put in place:

- The Lakeview Mental Health Specialist adds the appropriate Service Type and Treatment Mode/Form codes at the end of each entry on their 1009s.

- If a referral is made during a case management activity, the Lakeview Mental Health Specialist adds the appropriate Service Type code at the end of their 1009 entry, asterisk (*) this code, and, under the "Staff Notes" section, writes the SER referral code and the agency to which the case management referral was made.

The Mental Health Specialists at the Cook County Hospital, Englewood, and Woodlawn sites are responsible to complete the CHHAPS SER as originally intended.

There are two periods of time at which all four Mental Health Specialists may decide to complete the CHHAPS SER or 1009s for each of their clients. The forms may be completed directly after the service/s are provided, or Mental Health Specialists may opt to complete the forms at the end of each week. Use of the CHHAPS SERs and new way to complete 1009s began on September 1, 1996.

DATA COORDINATION OF THE FORM

Because the original administration plan of the CHHAPS SER was modified at one site in order to lessen the paperwork time spent by the Mental Health Specialist (see previous section), the role of the Data Coordinator has expanded to include more intensive quality control procedures. In order to manage his expanding role related to the multisite evaluation, the Project Director and Local Evaluator are enlisting the efforts of the Administrative Assistant regarding: a) data transfer from the 1009s to the multisite SER, b) data transfer from the CHHAPS SER to the multisite SER; and c) data entry of the SERs.

The majority of SER data entry is conducted by the Data Coordinator. During October, 1996, the Data Coordinator trained the Administrative Assistant on SER data entry. Regarding the specific procedures for data entry, the Data Coordinator organizes hard copies of "to be entered" SERs by site in separate manilla folders. After an SER has been entered either into the Administrative Assistant's computer or the main computer in the Project Director's office, the hard copy of the SER is stamped with the date of

APPENDIX H *(Continued)*

entry, paperclipped with other "entered" SERs, and placed back in the folder. The Data Coordinator then files the "entered" SERs by date of entry into the computer. If the Administrative Assistant's computer is used to enter SERs, the Data Coordinator downloads the latest SER data entries from this computer and uploads this information into the Project Director's computer before the weekly polling to the Coordinating Center takes place.

QUALITY CONTROL PROCEDURES

There are several quality control procedures in place to ensure that the SERs and 1009s are completed, transferred, and entered as intended:

- On a monthly basis, the Data Coordinator copies the SERs and 1009s, and files them along with the other information collected on each client (i.e., Participant Log, Interviewer Tracking Form) in a locked file cabinet in the central office at Cook County Hospital. Mental Health Specialists keep the originals in locked file cabinets at their respective sites.

- On a monthly basis, the Data Coordinator and the Mental Health Specialists review the forms to assure that standardized definitions are used by each of them and to assess the need for more multisite SER service type categories. This review of the form is also an opportunity for Mental Health Specialists to provide feedback regarding use of the forms.

On a quarterly basis, during local evaluation meetings, the Data Coordinator randomly selects forms, and asks Mental Health Specialists how they use certain codes (e.g., crisis intervention vs. psychotherapy/counseling focused on HIV testing). Discussion is encouraged.

APPENDIX I

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